National Center on
Health, Behavioral Health, and Safety

Head Start Oral Health Form—Pregnant Women and Pregnant People

Patient Information

Patient's name | Date of birth | Phone number

Address | City | State | Zip code

This practice is the patient's dental home: ○ Yes ○ No

Current Oral Health Status

Does the patient have any teeth with untreated decay? ○ Yes (decay) ☐ No (decay free)

Does the patient have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ○ Yes ☐ No

Does the patient have gum disease? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ○ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ○ Yes ○ No
Silver diamine fluoride: ☐ Yes ☐ No
Dental Sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Silver diamine fluoride: ☐ Yes ☐ No
Crowns: ○ Yes ○ No
Extractions: ○ Yes ☐ No
Emergency care: ○ Yes ☐ No
Other: _____
(Please specify)

Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Patient, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* | Phone number | Fax number

Practice name | Address

Provider signature | Date of service

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